MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Friday, October 11, 2002
8:58 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY ANN DePARLE
DAVID DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM: Introduction to the post-acute care episode
        database-- Nancy Ray, Sally Kaplan

        DR. KAPLAN: Nancy and I are doing the post-acute episode
database.
        At the retreat this summer you expressed interest in how
beneficiaries have changed their use of post-acute care after the
new prospective payment systems began for skilled nursing
facilities and for home health services. Answering this question
requires looking across post-acute care.
        Let me give you an example. The OIG has consistently found
that a group of costly patients has difficulty accessing SNF
care. These beneficiaries could be treated in rehab facilities,
or long term care hospitals, or could stay in an acute care
hospital longer. An episode database would allow us to determine
where those individuals go, and hopefully, what their outcomes
were.
        As you know, the SNF PPS began in January 1998. The home
health PPS began in October 2000. The PPSs for rehab facilities
and long term care hospitals just began this year in 2002. Rehab
began in January and long term care hospitals began on October 1.
        The main policy questions we hope to answer with this
episode database are on the screen. It is one tool that we can
use to answer these questions. In the past, MedPAC has used MCBS
data to answer similar questions about post-acute care. ProPAC
also built a claims-based database to assess use of post-acute
care, and so has MedPAC. However, they were constructed a little
bit differently.
        We'll be looking at these issues in two ways with the
analyses of the episode database, which we also call the claims-
based database, and with an MCBS analysis. However, our
presentation, Nancy and my presentation focuses on the claims-
based database.
        MS. RAY: I'd like to talk a little bit about the specifics
of the database at this point. We looked at a couple of
different alternatives but ultimately decided that using data
from 1996 to 2001 would best meet our needs to be able to track
people longitudinally over time. We also considered just using
two points of time, but with the different dates that the
prospective payment systems started, again we felt that the six-
year period, to begin with, would best meet our needs to be able
to identify post-acute users and follow them over time.
        We will be using the 5 percent files. We believe that that
will give us sufficient sample size to be able to look at both
national and regional trends. We estimate roughly about 50 per
year -- using the 5 percent files we would expect about 50,000
SNF users and approximately 200,000 home health users.
        Episodes of care will begin with either home health care use
or discharge from a hospital to a post-acute care setting. So
again, the definition of the episode differentiates this database
from previous work by allowing us to analyze folks coming from
the community into home health care. Finally, episodes will end

with a 31-day gap of services, hospice admission, M+C enrollment, or death.

I'd like to talk a little bit about the features of the episode database. We are trying to build upon previous Commission work, both with respect to our claims-based databases as well as our MCBS. We will be able to examine use of services before and after the numerous prospective payment systems that have gone into effect during this time period.

Because we are using the 5 percent files we will be able to look at service use for both Part A and Part B services. So for the first time we will be able to look and see what types of patterns of care are going on with Part B services, and the extent to which that has changed before and after the various implementation dates.

We will be differentiating beneficiaries based on their clinical characteristics, partly using the Part B diagnostic data as well as Part A that we will have. We will be looking at selected outcomes, rates of rehospitalization, rates of hospitalization, emergency department use, as well as mortality.

Finally, we will be merging in the SNF and home health cost report data to be able to estimate cost of care using the cost to charge ratios.

I'd like to talk a little bit about using the Part B services because I'm particularly excited by that. I think it will provide us a lot of new information to look at for our analysis. I'd like to make the point, and I should have previously, that we envision this as a growing database. When 2002 data arrive we will integrate that into the database and keep updating the database.

Using the Part B database will allow us to take a look at a question that I'm sure anybody else has looked at to this point, and that is to look at post-acute care use following outpatient surgery. Does it happen? Has it increased over time? Again, going back to our selected outcomes, we will be able to assess use of emergency department use within the episodes.

DR. KAPLAN: On the screen you'll see some examples of analyses. We plan to compare post-acute users and non-users, and find out what the differences are. Identify patient characteristics that predict use of more than one post-acute care setting, which has been -- in the past we've basically enumerated the number of beneficiaries that use more than one setting, but we really haven't tried to find out whether there are patient characteristics, or even facility characteristics, that predict that kind of use. Also, compare patterns of care pre and post-PPS, and compare outcomes pre and post-PPS.

We've contracted with Chris Hogan to build the database and conduct some of the analyses. Staff will use the database for other analyses, and we will continue to build and maintain the database as data for future years become available, as Nancy said.

Some of the analyses on the screen will be part of a chapter in the June report. Others will be used in next year's reports. However, I just want to make clear that we will not have any of the results available from this database for assessment of

payment adequacy for the March 2003 report, unfortunately. But we're very excited about having such a rich source of data available to answer questions and we're looking forward to reporting results from the analysis of the episode database.

We're happy to take your questions or comments at this time.

DR. NEWHOUSE: Sally, Nancy, I thought I heard you say you were going to construct this database by starting with either home health users who hadn't been admitted or discharges who used post-acute care. But then you said on the last slide, which I think you want to do, you want to compare post-acute users and non-users. So how are you going to identify non-users unless you include all discharges?

DR. KAPLAN: Okay, we'll have to use all hospital discharges. But we particularly want to capture those people who are referred from the community for home health.

DR. NEWHOUSE: I understand that. This is different.

DR. MILLER: Isn't the question, that's how you trigger an episode? That you'll have people with and without episodes in the database.

DR. KAPLAN: Yes, that's correct. I think what it is, the way the slide read was that people who are home health users who didn't have a hospital discharge, and then people who are discharged from the hospital.

DR. NEWHOUSE: But the text says, people discharged from a hospital who use post-acute. So you need the non-users of post-acute.

But then I have just a minor question going back to the exchange we had on the earlier session, which I think if you have all the discharges from hospitals, I think the hospital claim has a variable that tells you where they were admitted from. So I think you can then identify with the claims data the people that are coming from the nursing home.

DR. KAPLAN: I think that it does have that variable. I think there's an issue as to how reliable those data are. But we will investigate that because that's a good point, Joe. Thank you.

DR. ROWE: I'm wondering if there is a relationship or a possible relationship here between this database and the database of some of the health plans involved in the Medicare+Choice program. One of the major interventions that is introduced in patients with congestive heart failure, for instance, who have frequent readmissions and home health episodes are disease management programs that are managed by the health plans, or by vendors that are hired by the health plans.

I'm just wondering whether or not those Medicare beneficiaries in Medicare+Choice programs who would be enrolled in all these disease management programs, whether their data would be in this database and whether that would be potentially helpful or not. Would any of those be included in this?

DR. KAPLAN: Not if they were in M+C. If they're not in M+C, for instance if -- I don't know how that would work, whether you can have disease management independently.

DR. ROWE: Does CMS have disease management programs targeting --

DR. KAPLAN: Demos.

DR. ROWE: -- that would be relevant? Because this would be, obviously, a very rich database to look at in terms of the effect, if any, of these disease management programs.

DR. KAPLAN: I think those demos are just getting off the ground.

DR. MILLER: It won't be in this dataset, particularly for the years in question. That demonstration is just going. You can't get it, outside of M+C. That's a chronic problem with the claims data that when someone drops into M+C they drop out of the fee-for-service databases.

DR. ROWE: Thank you.

MS. RAPHAEL: A couple of questions. First of all, I think this is a very important and encouraging development that we're trying to construct this database. I've made this point at the retreat and I consider this really important, and you started out by saying this and I don't want to lose what I consider to be one of the most important things we have to look at. You started out by saying that there seems to be evidence that medically complex, clinically complex beneficiaries have trouble accessing nursing home care.

From my observation -- and this is not at all empirically based -- one of the things we have to be wary of with our prospective payment systems is that we're rewarding rehab services and rehab cases. We tend to gravitate to things we can more easily measure. I am concerned that medically complex patients are the ones who are having the hardest time across the post-acute care spectrum.

I'm not sure that I'm comfortable with how we're defining medically complex because, again, we're looking at things like stroke, vent dependency, et cetera. I think the medically complex patients who are having a hard time are those who have CHF, a variety of pulmonary diseases, or in most cases, more than one, and also have cognitive impairments. Those are the people that I think we have to somehow focus on in looking at this access issue. I'd like to better understand how we're going to ensure that we do that.

Then I think I'm also not entirely clear how we're going to compare outcomes from '96 through 2000 with whatever post-2001, because we didn't really look at outcomes in any structured way in the pre-PPS OASIS environment. So I'm not clear that we're going to be able to do that.

Then you also say you're going to be able to look at what influences choice of post-acute care setting. My own views are that very often this is driven by the need to discharge someone quickly and what services are available in a particular community, or families wanting services that have geographic proximity, rather than any sort of rational look at what are the options and what makes the best sense for a particular individual. So I'd like to better understand how you think you can contribute to that.

Lastly, on this issue of am-surg. We know that a large percentage of surgeries now are done on an ambulatory basis. What do you see is the significance of looking at that? Why

would it matter if more people in fact were coming into home health after am-surg rather than inpatient surgery? What would that tell us?

MS. RAY: Let me start. Let me just say, the selected outcomes we're initially going to be looking at will be rates of hospitalization, rehospitalization, emergency department use, and death. Ultimately, we will -- clearly, we will only be able to look at functional status changes after the implementation of the prospective payment systems, so I just wanted to clarify that point. So any kind of pre versus post-PPS will strictly be hospitalization, emergency department use, and death. That's all that we would be capable of doing with the claims data. That was one point.

Concerning your question about the choice of the post-acute care setting. You're 100 percent correct, there are a lot of other important factors that go into the decision of where somebody gets placed. In fact in MedPAC's MCBS analysis using the '92 through '97 data we saw that. One of the interesting variables that we saw was the hospital ownership of the SNF had a lot to do with where these folks were going.

So ultimately, with this claims-based database we will be merging that information into the database to go ahead and try to run out those multivariate regression analyses. Clearly, you can't control for everything. You can't control for -- particularly using the claims data, we don't have any information about informal caregiving. That is what we do have with the MCBS, which is why we really -- we're planning that these analyses will be running in parallel because there's some nice things about the MCBS data that you don't have with the claims, and then there's some nice features about the claims data that you don't have with the MCBS.

The ambulatory surgery. We don't know at this point, and I think it's just an open question, to what extent is post-acute care being used following ambulatory surgery. No, it does not replace in any way the inpatient
-- looking at post-acute care following inpatient hospital. This is a question that, probably not for the June report but further down the road we would like to look at.

DR. KAPLAN: Let me address the clinically complex issue and also the choice of post-acute care. Clinically complex, we have asked Chris to basically suggest to us the way he prefers to define clinically complex. We came up with two different ways of defining it. One is the Charlson comorbidity scale. Another way is using case-mix groups from 3M.

So that we would be able to, just using the diagnoses from the acute care claims, for post-acute care claims, and from the Part B claims it is possible to come up with basically a risk score that would say, these people are much more sick, clinically complex, than these people. I know that the 3M basically ranks them in four groups going from one to four, and the people who are in the fourth group are the most sick. So that is one way that we're talking about looking at the clinically complex.

In the mailing, we identified --

MS. RAPHAEL: That scale includes cognitive impairments?

DR. KAPLAN: I'm not sure about that. I don't know. We need to look into that. But cognitive impairment is very difficult because, unless it's in a diagnosis in the claim, it's not going to be there. The only way you're going to be able to tell it is from the assessment instruments, which mean you'll have it for home health, you'll have it for MDS or for the SNF patients, but you won't have it for the others.

MS. RAY: And you'll only have that post-PPS. Another limitation.

DR. MILLER: Can I ask one question about that? If the person comes from the hospital -- and this is not completely through the database, but if they come from the hospital there can be a diagnosis code attached there, like a dementia code?

DR. KAPLAN: That's true, but it isn't --

MR. MULLER: It won't be the lead one, by and large, so generally you won't get it.

DR. MILLER: Agreed. But if there's any way to reach -- I think what I'm saying is, if there's any way we can troll through the data to see if there is a way to reach to this question. I think you're right about the assessment instruments. But if they come out of a hospital I think you might be able, somewhere down on the diagnosis code, figure out whether dementia was part of it.

DR. KAPLAN: That's one reason why we're using the diagnoses from all these sources, so that you'll get all of the diagnoses. But you still have a limitation as to how many diagnoses, even on the acute care claim you have a principal diagnosis and then 10, used to be called secondary diagnoses.

Let me also address the issue of choice of post-acute care. I think what we're looking for here are systematic predictors of using a particular site. As Nancy said, there are limitations on that, particularly because caregiving we know is very important in the home health, SNF area, and even in rehab it's been shown to be important. But it will at least give us some idea of if there are systematic predictors of a particular site or not.

DR. REISCHAUER: I think this is a tremendous tool and one that, if we're able to pull it off, will be tremendously useful over a long period of time. It's a huge undertaking and I guess we'll be seeing both of you again and again with progress reports.

In a way you've answered my question, I think, which is, a lot of the answers to questions depend critically on demography and geography, and the database really won't have any or much in the way of characteristics of the environment in which the patient lives, meaning family status, income, or information about availability of post-acute care facilities in the -- it will? That's great.

MS. RAY: We will be able to -- ultimately, we are planning on merging in and controlling for number of other providers in the area and so forth. But you're right, using the claims data we won't be able to get beneficiary income or educational status. Again, we can look at that using the MCBS data; another advantage of the MCBS data.

DR. NEWHOUSE: I second Bob's views about the usefulness of

this. I suspect the world will be beating a path to your door.
But my question goes to the use of the outcome variables, death,
readmission, and so forth. We know that for many years there's
been a downward trend in both mortality and disability in the
Medicare population and especially in the very old.
     DR. ROWE: That would be a reduction --
     DR. NEWHOUSE: An increase in life expectancy. It would
seem at first blush that this is confounded, this is going to
confound your analysis of death rates as these prospective
payment systems march in through time. How do you plan to handle
that?
     DR. KAPLAN: One of the things that we thought about using
and we're planning on using in the long term care hospital
analysis was to use expected versus actual death. But I'm not
sure how -- we haven't really worked out the details of that, to
tell you the truth, on the episode database.
     DR. NEWHOUSE: Because even expected death, that presumably
is changing through time.
     MS. RAY: I think you're raising a good point and we will
definitely get back to you on that.
     MR. MULLER: Let me echo the compliments on the potential
utility of this database. I think the population that both your
brief and Carol referred to earlier, the medically complex and
the clinically complex are fascinating cases we want to get to
understand more fully.
     As people go more into disease management programs, and I
suspect that these people we're speaking about here are going to
be candidates for that, will we be losing some of the data
richness on that, comparable to what Jack referenced earlier in
terms of what you lose when you go to M+C, because all of the
sudden now the kind of claims, the kind of granularity of the
claims data is no longer available. But in the disease
management programs we still get the acute hospitalizations,
there's ER, there's ambulatory surgeries, there's all the kind of
different episodes of care they have.
     MS. RAY: Initially our analysis, the '96 through 2001 --
the disease management demos aren't starting until I guess next
year -- this year, next year? So that's not an issue. The only
disease management one that's actually completed is the ESRD
disease management, and that was a pretty small program.
     So ultimately in the future, that could definitely be an
issue we consider, is to specifically -- first of all, see the
population and whether or not we have sufficient population to
look at those folks separately.
     MR. MULLER: What I'm suggesting is that as we do the
medically appropriate thing and as they bundle care and have
people who case manage and otherwise are more responsible for
taking care of a vulnerable population that needs a whole array
of services, one of the data ironies may be, however, that we now
lose the information on what we're doing. For a clinically
appropriate purpose.
     So I'm not suggesting that's the wrong way to manage the
care, although we may also lose the richness of that data, if
indeed the kind of predictions that we'll more and more of these

vulnerable populations into disease management programs. Because the kind of people that Carol referenced, the congestive heart failures, the pulmonary cases, the ones that have dementia as well as medically complex needs.

I'm just thinking -- I understand the point that we don't have enough of those programs yet to worry about it. But on the other hand, if that becomes the clinically appropriate way of caring for these people with multiple needs -- and I think there's a lot of speculation, at least in the clinical literature that that's the right way to do it -- we may, on the other hand, want to be attentive to keeping some information about that so we don't lose the kind of information that we lost in M+C. Again, M+C was an appropriate policy choice to make, but then you lose information on patients.

MR. DeBUSK: In the examples of analyses, the second bullet point, identify patient characteristics that predict use of more than one post-acute setting, will you be looking at the financial aspects of the handoff process there? That's a major issue as to how that takes place at present.

DR. KAPLAN: You're talking about the incentives to transfer somebody to another setting?

MR. DeBUSK: Exactly.

DR. KAPLAN: I think we'd like to, to the extent that we can. I'm not sure whether we're really going to be able to answer that. I think part of what we were thinking about was that we know there's a lot of home health use following hospital use, which is a multiple setting use. So are there patient characteristics that basically predict that? Either particular -- does it happen for particular conditions, and distinguishing between that type of -- that actually is something that's recommended according to the clinical guidelines. So that's a little bit different type of multiple use of the financial incentives say, keep churning them through.

MR. DeBUSK: But these characteristics, patient characteristics, they're all going to play into that as to what actually happens. I think there would be some trends in your analysis that would probably indicate, here's where these handoffs are taking place, and here's why.

DR. KAPLAN: I think there will certainly be some clues. I don't know that we'll get a definitive answer.

MR. HACKBARTH: Any other questions or comments?

Okay, thank you.